



**Division of Regulation and Licensure
Section for Long Term Care Regulation**

LTC BULLETIN

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Drug's side effects cause residents to test positive for marijuana

*By Janesta Ellison, Facility Advisory Nurse
Poplar Bluff Section for Long Term Care Regulation*

Three emergency departments from different cities recently called the Elder Abuse and Neglect Hotline, indicating that elderly long term care residents in their care had tested positive for tetrahydrocannabinol (THC) or marijuana. The Section for Long Term Care Regulation investigated the reports, as well as two others involving residents who tested positive for THC.

The section initially found the residents were transferred to the hospitals for evaluation of altered mental status (AMS). Physicians often perform a urine drug screening to evaluate AMS. The test typically screens for the presence of opiates, barbiturates, benzodiazepines, alcohol, cocaine, and cannabinoids or THC. Test results are either "positive" or "negative." Presumably, the physicians doubted the residents could gain access to marijuana on their own and believed an unknown person or persons had added it to their food, or exposed the residents by other means. That's why they called the hotline.

As it turns out, all of the residents had been prescribed pantoprazole (Protonix), a proton

pump inhibitor used to treat gastroesophageal reflux disease (GERD). A side effect of this drug can be that one tests positive for marijuana use. In the Physicians' Desk Reference, the manufacturer of Protonix says: "There have been reports of false-positive urine screening tests for THC in patients receiving most proton pump inhibitors (PPI), including pantoprazole. An

alternative confirmatory method should be considered to verify positive results." (Other PPI include Prilosec, Nexium, Prevacid, and Aciphex.) According to the Merck Manual, several other commonly used medications may produce false-positive THC results. They include, for example, Tegretol, Librium, Clozaril, Lodine, Wytensin, Paxil, and Zocor.



Prescription drugs can affect how our bodies absorb, use, and excrete nutrients in our food. As we age, our bodies have less muscle and more fat; and, our kidneys, heart, liver and intestines tend to function less efficiently. As we take care of our residents, it is important to be aware and more sensitive to the side effects of drugs.

RESTRAINTS

Are They Really a Safety Net?

*By Joan Brundick,
State RAI Coordinator*

Physical restraints are receiving more and more attention these days, and rightfully so. Far from being a safety net, as many think, they are instead a last-resort measure that can lead to serious injury or even death. Federal regulation 483.13(a) states, “The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident’s medical symptoms.” “Preventing a resident from falling” is not considered a medical symptom; in fact, restraints used for this purpose are considered a staffing convenience, which is prohibited.

The Centers for Medicare and Medicaid Services (CMS) guidelines are very clear that restraint use should be the exception, not the rule. Although CMS does not require restraint-free facilities, it does advocate for them through clinical best practices. Physical restraints are defined as any physical or mechanical device, material, or equipment, attached or adjacent to the resident’s body, that the individual cannot remove easily and that restricts freedom of movement or normal access to one’s body.

When would a physical restraint be used? Individual assessment is the key. A device in and of itself is not a physical restraint. A device may be a restraint for one resident, but not another. Each person’s situation is different and needs to be assessed individually (sounds like person-centered care).

When restraints are used, a physician must order them, and the order is issued to treat a resident’s well-documented medical symptoms. Further, a facility must inform the resident of the

restraints’ potential risks and benefits, as well as other options. If a resident is incapable of making a decision, his or her legal surrogate or representative may do so. However, since restraint use can reduce independence, functional capacity and quality of life, the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience, or if a restraint is not necessary to treat the resident’s medical symptoms. A facility also has the responsibility to assess restraint use on an ongoing basis. Doing so during a quarterly care-plan review should suffice, as long as a resident’s condition has not changed in the interim. A resident who needs a restraint today may not need one tomorrow or in three months.

An assessor must look at the restraint’s effect on an individual’s functional ability. If a device prevents a resident from doing normal abilities, it is a restraint. Also remember that side rails can be a restraint. If a device keeps a resident from doing something they otherwise could do (i.e. get out of bed), it is a restraint. However, sometimes a resident incapable of getting up from any chair may want to recline in a chair; in this instance, granting the resident’s wish may be considered a comfort measure rather than a restraint.

Facilities are to provide optimal quality of care and quality of life for their residents. For each resident, a facility should ask: “What have we done to make this the best possible environment for this resident?” One of the best trainings on restraints started with a speaker asking the audience, “What type of restraint do you want when you go to a nursing home?” If you are like most of us, the answer will be “NONE!”



TOP PRIORITY

Given to Reducing Pressure Ulcers and Restraint Use in Nursing Homes

By Natalie Fieleke, MA
Primaris



This fall, Primaris launches several quality improvement efforts to reduce the incidence and severity of acquired pressure ulcers and restraint use in Missouri's nursing homes.

Direct and indirect costs of pressure ulcers and restraint use continue to rise, and nursing home residents' quality of life is negatively impacted. Twelve percent of high-risk, long-stay residents and two percent of low-risk residents in Missouri nursing homes have pressure ulcers, according to the Centers for Medicare and Medicaid Services' (CMS) *Nursing Home Compare* Web site.

Restraints and pressure ulcers often go hand-in-hand as physically restraining an individual can lead to pressure ulcers. Nationwide, five percent of long-stay residents are physically restrained. Even more in Missouri – six percent – are restrained. People who are restrained daily can become weak and lose their ability to go to the bathroom by themselves. Restraint use may even contribute or worsen other medical conditions.

Research shows that pressure ulcers and restraint use are complex issues and often require a transformation in management, leadership and clinical practice to make a significant difference. Primaris plans to help nursing home leaders become better able to utilize staff, one of their most valuable resources. A stable, educated, empowered staff creates improved clinical outcomes, reduces costs, satisfies consumers and improves quality of life for elders.

Additionally, working to reduce pressure ulcers takes collaboration between nursing homes and hospitals. Primaris will introduce a model in bringing these two groups together because twenty percent of pressure ulcers originate outside a nursing home, generally in the acute hospital setting. The 2004 national incidence rate for hospital-acquired pressure ulcers was 7.7 percent. A 2006 study indicates the cost for healing one pressure ulcer can range from several hundred to as much as \$27,000.

Facilities that choose to participate in the voluntary collaboration will benefit from a Medicare resource that is not available to every hospital and nursing home. Contact Natalie Fieleke at nfieleke@primaris.org to learn more about upcoming projects.

About Primaris:

Primaris is a nonprofit, health care consulting firm and contracts with CMS to serve as Missouri's Quality Improvement Organization. Primaris' mission is to improve health care delivery and outcomes by promoting excellence, advancing knowledge and developing innovative solutions for physicians, other providers, businesses, government, patients and consumers.

TOP 10 Deficiency List **SPARKS** Interest

For several years, the Section for Long Term Care Regulation (SLCR) has provided the top ten deficiency list to long term care facilities, associations and advocacy groups. Requests for the list have increased; therefore, it will be posted quarterly in the *LTC Information Update* LISTSERV. The top ten deficiency list includes Missouri's most frequently cited Health and Life Safety Code deficiencies for Medicare- and/or Medicaid-skilled nursing facilities.

This article includes Missouri's most frequently cited Life Safety Code deficiencies from January 1, 2008 - March 31, 2008. The next issue of the *LTC Bulletin* will include the most frequently cited Health deficiencies.

As we all work toward ensuring and providing a high quality of care and life for residents, it is our sincere hope that each facility administrator and their management team will review the list and use it as a tool for increased awareness and quality assurance. Each K-tag listed includes examples of the issues frequently cited.

Life Safety Code Deficiencies:

K-62: Sprinkler maintenance

Common citations:

- Failure to conduct or document inspection of sprinklers as required by the National Fire Protection Association (NFPA) 25
- Failure to complete inspections on a weekly, monthly, quarterly and annual basis

K-18: Corridor doors – resistance of the passage of smoke, easily closable, and has positive latching

Common citations:

- Failure to ensure that there are no gaps around the door edges
- Failure to ensure latches operate
- Failure to ensure there are no obstructions preventing the door from closing easily (e.g. door wedges)
- Failure to ensure required automatic door closures are operating

K-46: Battery operated emergency lighting

Common citations:

- Failure to provide emergency lighting for the outside exit pathways
- Failure to operate when tested during the inspections
- Failure to complete testing or documentation of the monthly and annual testing

K-56: Sprinkler systems

Common citations:

- Failure to provide sprinkler head coverage in all spaces, as required by NFPA 13
- Failure to ensure sprinkler heads are not damaged or corroded
- Failure to ensure that sprinkler coverage is not obstructed by storage or other fixtures (e.g. lights, curtains, etc.)

TOP 10...

K-54: Smoke detector maintenance

Common citation:

- Failure to provide all smoke detectors with annual sensitivity tests and document results of each detector

K-38: Exit access

Common citation:

- Failure to provide an all weather sidewalk, typically a concrete pathway, from an outside exit to the public way or street

K-29: Hazardous areas

Common citations:

- Failure to ensure doors are self-closing
- Failure to ensure doors are appropriately fire-rated (typically 45-minute fire-rated and labeled)
- Failure to ensure walls/ceilings are rated to the full one-hour rating

K-66: Smoking regulations

Common citations:

- Failure to ensure smoking areas are provided with self-closing cans and/or used exclusively for the disposal of smoking materials
- Failure to ensure smoking and other flammable materials are not disposed of in regular trashcans
- Failure to ensure ashtrays used are of safe design (e.g. paper cups)

K-12: Construction type

Common citations:

- Failure to ensure structure is protected with the appropriate fire rating (e.g. replaced fire-rated ceiling tiles with non-rated tiles)
- Failure to prevent a structure addition or modification, consequently changing the construction type

K-147: Electrical wiring

Common citations:

- Failure to properly use electrical surge protectors and extension cords (e.g. too many or high usage items used on surge protectors, more than one item on an extension cord)
- Failure to ensure plug adaptors are not used with duplex receptacles with several items plugged into one outlet
- Failure to ensure safe wiring practices (e.g. wiring spliced outside of junction boxes, splices taped, etc.)



Coming to a facility near you...

MINIMUM DATA SET 3.0

The Minimum Data Set (MDS) 3.0 is scheduled for implementation October 2009. The Statewide MDS Training Committee is already working on the 2009 training, but what about now....

The Statewide Committee strongly recommends that all MDS Coordinators who have not attended the statewide training program, *MDS/RAI Process – One Step at a Time*, to sign up for the October 2008 training. The coordinators will obtain the knowledge of the Resident Assessment Instrument (RAI) process and MDS 2.0 by attending this training and will gain a better understanding of the changes brought about by MDS 3.0.

The training for MDS 3.0 will begin when the final 3.0 version and the accompanying RAI Manual are available. Any attempts of training before receiving the materials would be futile. Once the necessary materials are available, there will be training statewide to ensure everyone has an opportunity to attend.

The RAI process begins with the MDS, which leads into all aspects of resident-centered care within your nursing home. The MDS Coordinator is pivotal in ensuring appropriate, quality care is provided to residents and accurate information is provided for the quality measures and indicators, and the billing process. When there is frequent or high turnover in this position, the result can lead to unsuccessful consequences.

What can you do to invest in your MDS Coordinator and your nursing home?

Reap the investment by providing:

- Standardized training: *MDS/RAI Process - One Step at a Time* is co-sponsored by various statewide long term care organizations. The 2-day workshop is \$245, which can easily be recovered in more accurate coding. For additional information, go to: <http://web.mhanet.com/asp/Education/Seminars.asp>
- Independent Study: *Nursing Home Help* is a Web site that offers MDS Coordinators an independent study to do at their own pace called *MDS Version 2.0 - Item by Item Quick Reference and Self Study Guide*. To obtain this guide, click on <http://www.nursinghomehelp.org> and then click on "Education." The Centers for Medicare and Medicaid Services also has an on-line training at: <http://www.mdstraining.org/upfront/u1.asp>
- On-going training: Each long term care region of the state has a MDS Coordinator Support Group that meets to help coordinators stay current on MDS information. For dates and locations in your region, go to: <http://www.nursinghomehelp.org/supgr.html>
- On-site assistance: The Quality Improvement Program for Missouri (QIPMO) offers free on-site assistance to your MDS Coordinator. To reach a nurse in your area, contact Jessica Mueller at muellerjes@missouri.edu or (573) 882-0241.



In Simple Terms...

Nursing Home Surety Bonds and Riders Noncancelable Escrow Agreements

*By Sandy Rackers, Accountant
Section for Long Term Care Regulation*

Missouri law requires long term care facility operators to file a surety bond with the Section for Long Term Care Regulation (SLCR) if they hold residents' personal funds in trust. The law also allows the operator to place cash deposits held in noncancelable escrow agreements to satisfy this requirement.

SLCR must review surety bonds and noncancelable escrow agreements; therefore, the operator must meet the following criteria:

- The surety bond or noncancelable escrow agreement must have a minimum amount of \$1,000.
- The surety bond or noncancelable escrow agreement must be at or greater than 1 ½ times the average monthly or total balance of residents' funds rounded to the nearest \$1,000.
- If the operator chooses to obtain and file a surety bond to meet this requirement, the operator will need to submit the information regarding the amount of surety obtained on a Nursing Home Surety Bond form (MO 580-2624). SLCR must have the original form to approve its usage in the facility.
- If the operator chooses to deposit cash in a noncancelable escrow agreement, the operator must submit the required information on the Noncancelable Escrow Agreement form (MO 580-2628). The operator and banking institution must complete the form and submit it with proof of the deposit
- All original forms must be mailed to SLCR Licensure and Certification Unit. The forms are available on the Web site at www.dhss.mo.gov for completion and approval.

Once SLCR approves the surety bond or escrow agreement, the long term care facility will receive an approval letter from SLCR Licensure and Certification Unit with a copy of the stamp-approved and dated surety bond or rider.

Helpful Hints:

Take a few moments to review your current bond or escrow agreement. The operator needs to ensure it is in the proper amount. Any changes to the bond amount, including the use of a rider, must be submitted to SLCR Licensure and Certification Unit. If you discover a bond or rider that appears to be an original and not stamp-approved by SLCR, mail the documents to SLCR Licensure and Certification Unit for processing. Contact SLCR if you feel that you have a bond that has been or needs to be cancelled.

Questions? Contact the SLCR Licensure and Certification Unit, Accountants at:
Section for Long Term Care Regulation
P.O. Box 570
Jefferson City, MO 65102-0570
Phone: (573) 522-9812 or (573) 526-3630

Department of Mental Health (DMH) Licensure

Frequently Asked Questions

1. In what circumstances is a DMH license required for a residential facility or day program?

If a facility's resident or day program population includes 51% of individuals with a diagnosis of a mental illness or one individual with a diagnosis of mental retardation, the facility is required to have a DMH license. The Missouri statute governing this requirement is RSMo 630.705.

2. What if the facility or program does not receive any DMH funding?

The statutory requirement for DMH licensure is not dependent upon funding or contracting with DMH. It speaks only to the type of diagnosis and makeup of the resident population.

3. Does DMH also license Skilled Nursing Facilities?

DMH does not license skilled facilities participating in federal Medicare and Medicaid programs. There is a clause in the statutes that allow for this. However, if the facility does not participate in these federal programs and the facility meets the thresholds described in question #1, DMH licensure would be required.

4. Are there any other exceptions?

A DMH license is not required if the facility is accredited by:

- *Commission on Accreditation of Rehabilitation Facilities (CARF);*
- *Joint Commission for Accreditation of Healthcare Organizations (JCAHO);*
- *Council for Quality and Leadership (CQL), formerly known as Accreditation Council (ACDD);*
- *Council on Accreditation of Services for Children and Families (COA); or*
- *American Osteopathic Association (AOA).*

A DMH license is not required for a facility or program with less than four persons and is not funded by DMH.

5. If I obtain a DMH license, am I obligated to contract with DMH and accept DMH consumers?

Licensure by DMH does not obligate the facility/program to enter into a contract with DMH nor to accept DMH consumer placements. Conversely, the fact that a facility/program may be licensed by DMH does not obligate DMH to contract or provide funding.

Department of Mental Health (DMH) Licensure

Frequently Asked Questions

6. How much does it cost to obtain a DMH license?

Cost depends upon the size of a facility/program. One with 10 or more residents pay \$50.00; those with at least four but less than 10 pay \$10.00; those with three or fewer do not pay a fee.

7. If I currently hold a Residential Care or Assisted Living license from the Department of Health and Senior Services (DHSS), what additional requirements does DMH have?

DMH rules are designed to limit duplication of DHSS requirements. DMH rules include items related to policies and procedures, consumer rights, admission criteria, and care and treatment of persons with mental illness or mental retardation. These are found in 9 CSR 40-Chapter 2 and Chapter 3.

8. How do I apply for DMH licensure?

To obtain an application, contact DMH Licensure and Certification Unit either by phone at (573) 751-4024 or in writing addressed to: Licensure and Certification Unit, Department of Mental Health, P.O. Box 687, Jefferson City, MO 65102. Currently the application is not available at the DMH web site. For facilities licensed by DHSS, the DHSS license must be current and in good standing in order for the DMH application to be considered.

9. After I apply, what occurs?

Once a completed application and fee (if required) is received, it will be forwarded to the applicable regional office and assigned to a surveyor. The surveyor will schedule a time to travel to the facility to conduct a review and determine compliance with DMH requirements. A report will be generated summarizing this review. If all requirements are met, a license will be issued. If all requirements are not met, the facility must submit a plan of correction. If a plan of correction is required, an additional review will be done to determine compliance with standards. If compliance is not achieved, a license will be denied.

Questions or Information:

Jane Perry, DMH Director of Licensure and Certification

Phone: (573) 751-4024

Missouri Department of Health and
Senior Services
Section for Long Term Care Regulation
P.O. Box 570
Jefferson City, MO 65102-0570

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